EXHIBIT 260

REVIEW OF THE PARK CENTRE FOR MENTAL HEALTH
UNDERTAKEN MARCH/APRIL 2012
KARLYN CHETTLEBURGH AND HELEN DOYLE

1. EXECUTIVE SUMMARY

This Review was established as a collaborative process between the Mental Health Alcohol and Other Drugs Directorate (MHAODD), West Moreton Health Service District and was supported by Karlyn Chettleburgh, Executive Director Mental Health & ATODS, Gold Coast Health Service District. The context for the Review is the current financial position facing The Park with a projected deficit of close to $5,000,000 for the 2011/12 financial year.
A number of factors have complicated the operational and financial environment of The Park. These include the management of clients who have imposed management plans that are extremely resource intensive and the current redevelopment program of The Park which has established a range of targets involving beds closures, consumer relocation and associated financial recalibration.
Whilst formal terms of reference were not provided, the scope of the review was to;

- Ensure that management has pulled the levers available to control the current expenditure patterns (particularly related to the management of clients and the Adolescent Unit) but have been unable to do so due to the unusual nature of the demands.
- Assist with planning to reign the current expenditure in over the next 12 to 18 months.
- Provide advice to the District to assist with their brief to the DG.

Ms Helen Doyle was made available by the MHAODD to provide support and advice regarding The Park redevelopment program and associated reform activities.

Associate Professor Mark Keiran and Mr William Brennan were allocated as the key contacts for West Moreton HSD and The Park. Initially it was identified that the review would be undertaken within a short time frame and would take no more than 2 working days over a 2 week period, however this has not been possible due to the other commitments of the individuals undertaking the review and the complexity of the issues.

It is important to note the commitment of the leadership team at The Park to achieve clinical and operational reform. It was evident that significant efforts have been made to engage staff and the industrial bodies to achieve the required outcomes and a commitment to high quality and contemporary consumer care is at the core of management decision making. An example of this has been the recent change to seclusion practices at The Park which has resulted in more therapeutically engaging interventions. The demonstrated reduction in seclusion as a consequence in this change is commendable and staff and management should be proud of this achievement.

Outlined below is a summary of the recommendations made to assist the District in further progressing the redevelopment and reform agenda and to provide a platform for sound financial management of the Parks resources.

1.1 Summary of Recommendations

1. Review the nursing skill mix and profile for each inpatient unit and identify opportunities to replace Registered Nursing positions with Enrolled Nurse and Enrolled Nurse Advanced Practice positions.

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2. Following completion of recommendation 1 establish the Nursing BPF for The Park ensuring unfunded and not approved positions are not embedded within the BPF profile.
3. Place a hold on further establishment and recruitment to nursing positions until it is clear that deployment of surplus to requirements staff have been appropriately deployed to existing vacancies.
4. The role and function of the Mental Health Rehabilitation Service be reviewed at the first available opportunity with a goal of more effective integration with clinical teams and to identify cost savings.
5. Review and/or establish partnership agreements with relevant Non-Government Organisations to provide clarity regarding issues such as liability and access to District resources.
6. Expedite the recruitment to the key Divisional positions of; Executive Director Mental Health and Business Manager Mental Health.
7. As a matter of priority review the February 2012 Business Case for Change to ensure that the proposed staffing profiles are affordable and consistent with operational and clinical requirements.
8. Develop a 'sliding scale' of resource allocation to match staffing levels with occupancy and thereby activity for all inpatient units, particularly the Barrett Adolescent Unit.
9. In the absence of 'High Acuity' being ceased, develop and document a procedure that clearly articulates the criteria, authorisation and process for it's use.
10. WMHSD, the MHAODD and MSHSD work together to reach agreement on funding transfer amounts related for service relocations and to coordinate other important aspects of the redevelopment process including workforce related issues.
11. Explore options for ensuring revenue associated with consumer fees is realised.
12. Obtain a further second opinion for diagnostic and placement purposes for
13. Re-negotiate staff supervision requirements for with Queensland Correctional Services.
14. Develop and inter-departmental agreement between Queensland Health and Queensland Correctional Services that can assist The Park in recouping additional costs associated with the management of In the absence of a transfer of funds being viable 'debt forgiveness' to the equivalent of the additional cost should be made available to The Park.
15. Review the possibility of transferring to the more secure Prison Ward at Princess Alexander Hospital.
16. Re-refer to the Forensic Disability Unit
17. Develop and inter-departmental agreement between Queensland Health and Disability Services Queensland that can assist The Park in recouping additional costs associated with the management of In the absence of a transfer of funds being viable 'debt forgiveness' to the equivalent of the additional cost should be made available to The Park.

2. BACKGROUND

This Review was established as a collaborative process between the Mental Health Alcohol and Other Drugs Directorate (MHAODD), West Moreton Health Service District and was supported by Karlyn Chettleburgh, Executive Director Mental Health & ATODS, Gold Coast Health Service District. The context for the Review is the current financial position facing The Park with a projected deficit of close to $5,000,000 for the 2011/12 financial year.
A number of factors have complicated the operational and financial environment of The Park. These include the management of clients who have imposed management plans that are extremely resource intensive and the current redevelopment program of The Park which has established a range of targets involving beds closures, consumer relocation and associated financial recalibration.
Whilst formal terms of reference were not provided the scope of the review was to;

- Ensure that management has pulled the levers available to control the current expenditure patterns (particularly related to the management of lients and the Adolescent Unit) but have been unable to do so due to the unusual nature of the demands.
- Assist with planning to reign the current expenditure in over the next 12 to 18 months.
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Ms Helen Doyle was made available by the MHAODD to provide support and advice regarding The Park redevelopment program and associated reform activities.

The Park, formerly known as Wolston Park Hospital, was established in 1865, and is part of the West Moreton Health Service District. The implementation of the *Ten Year Mental Health Strategy for Queensland* (1996) saw the beginning of the transition of institution-based rehabilitation services to community based care models of care. The Park remains one of the largest mental health facilities in Australia, with a total of 192 beds across the following service types:

- Extended treatment and rehabilitation beds (ETR) for people with a chronic mental disorder requiring extended consumer care and rehabilitation;
- Dual diagnosis beds (DD) for people with a mental disorder who are also intellectually disabled who require extended consumer care and rehabilitation
- Secure mental health rehabilitation unit beds (SMHRU)(previously known as Medium Secure Beds) for people requiring extended consumer care and rehabilitation within a secure environment
- High Security beds for people requiring consumer care and treatment for a mental illness as well as requiring a high security environment.
- Extended treatment (ET) adolescent rehabilitation beds for young people who require extended consumer care and treatment for a mental illness and
- Mental Health research and education.

The *Queensland Plan for Mental Health 2007-17* (QPMH) provided a reform agenda for The Park which would result in further progress towards the deinstitutionalisation of ETR and DD services and a change in the profile of service delivery at The Park to provide forensic and secure mental health services. The overall impact of downsizing under Stage 1 was to reduce beds from 192 beds in 2006/07 to 152 beds by 2012, to be achieved through:

- Transfer of DD and ETR beds to four new Community Care Units located within the catchment area;
- Transfer of consumers with intellectual disability to services provided by the Department of Communities where appropriate;

- An overall reduction in Extended Treatment Rehabilitation/Dual Diagnosis (ETR/DD)beds from 82 to 28 beds (to be provided in one ETR/DD unit as an interim measure until further deinstitutionisation is possible)
- Development of nine new beds for the High Secure Unit (operational since January 2012);
- Development of a new 20-bed extended treatment and rehabilitation forensic unit (due to commence operation mid-2012);
- Transfer of beds from the Barrett Adolescent centre to a new extended treatment adolescent mental health unit at a more appropriate site at Redlands (due for completion in 2014).

3. FINDINGS AND RECOMMENDATIONS- General and financial

3.1 Workforce Management

Staff ratios and skill mix

A number of factors that are contributors to staffing profiles and skill mix at The Park are complicated by the redevelopment program that is currently occurring. In addition there is a long standing cultural and industrial environment that does not embrace change and alternate models of service. Having said this, there is an opportunity to review and reform staffing profiles and skill mix at The Park. It would be inappropriate to underestimate the level of research/benchmarking, consideration and consultation required to establish what would be an 'ideal' staffing profile for each of The Park's unique services and the scope of this review does not allow for the time and resources necessary to undertake this. Therefore, this review will provide a number of 'markers' for areas that would benefit from further review and reform regarding staffing levels and skill mix. The areas that should be further considered include;

- Ratio of Registered Nurses to Enrolled Nurses (in some areas the ratio is 1.5 to 25), including further encouragement and support for the establishment of ENAP positions. It is not unreasonable to establish a target of 25% of the nursing workforce to be qualified Enrolled Nurses.
- Introduction of AIN (nursing assistant) roles within some areas of operation where there is a high level of task oriented activities focused on activities of daily living (eg/ Dual Diagnosis and Extended Treatment and Rehabilitation environments where some consumers are stable but physically frail, or where there is a high level of institutionalised based disability).
- Clearer role and responsibility definitions between consumer based allied health staff, nursing staff and the rehabilitation service (further discussion regarding the role of the rehabilitation service will occur later in the review report).
- Establishment of a nursing BPF that has expert input to ensure that the 'formula' that is used for the establishment of the BPF does not embed unfunded and not approved FTE/positions within the BPF.

There are a number of long term casual staff working in the Barrett Adolescent Unit (BAU). It was suggested that the current staffing mix is not the most appropriate for provision of ET adolescent services. The status of these long term casual staff may have an impact on the capacity to change the skill mix as there may be industrial requirements that would consider these 'casual' staff to have the same entitlements as permanent employees. There have been discussions about employing permanently to positions in anticipation of staff, as well as consumer, transfer to Metro South Health Service District when the new unit is built, however we were advised that at this stage Metro South appear to be reluctant to become actively involved. It is anticipated that there will be a need to recruit to the NUM position of the Adolescent Unit following the pending retirement of the current NUM. Strategically, The Park would like to have a recruitment process for this important position that is a collaboration between their District and MSHSD, however whilst there is continued reluctance by MSHSD to engage with The Park this may not be able to occur. The approach expressed to the review team was that due to capital works delays at the new site, BAU is now being treated as though it is not being relocated. Whilst this is a pragmatic response in an attempt to address staff morale issues and the current uncertainty, this may not be helpful in the longer term as it will result in the change management process needing to be recommenced. It will be important to try to develop an approach that keeps staff focused on the future relocation whilst creating a sense of stability.

This is work that should be undertaken by the Redevelopment Team in collaboration with the NUM and other operational management staff.

Graduate positions:

- Previously there were 32 graduate nursing positions at The Park – as the size of The Park has reduced it was reported that there was an over-reliance on graduate nurses – which led to industrial issues (AWU concerns about staffing mix). As a consequence Graduate nursing positions have been reduced from 32 to 25, and seven positions have been converted to Registered Nurse positions and made substantiative. Whilst this change has had a positive impact on skill mix, in the longer term it will have an impact upon the costs associated with the seven converted positions as yearly increments will be applied. In addition these positions are now substantively occupied and therefore this potentially adds to the number of staff who may be surplus to requirements as The Park downsizes. It has been suggested however that the reduction in graduate nurses also reflects the early drop out rate and therefore the need to backfill the vacant graduate nurse positions with expensive overtime or casual staff use.

Casual, Agency and Nursing Pool

- We were advised that there has been an over reliance upon casual staff as a result of uncertainty regarding the time frames for bed closures and/or consumer relocation and an appropriately conservative approach to minimising the number of permanently appointed staff to reduce the risk of surplus employees. A 'freeze' had been placed on recruitment however a decision was made to lift this freeze in December 2011 in an attempt to reduce the number of casual staff employed and to provide greater workforce stability. As a result an additional 15 staff were employed. Whether this should have been necessary when there should be staff reductions associated with actual and planned bed closures will be explored further in the Redevelopment section.
- It was reported that the Business Rules/Rostering Principles have not always been adhered to as a result of high levels of staff vacancy and utilisation of casual, agency and overtime shifts. Reinforcement of the requirement to comply with the rostering principles has recently seen a greater compliance by the After Hours Coordinators.
- Currently the Nursing Management area is highlighted as being significantly over budget with the profile being 16 FTE above approved and funded establishment. It would appear this is as a result of 16 FTE of casual nursing staff currently sitting within the Nursing Management cost centre and efforts to have these positions reallocated to the cost centres that they are currently working in have been unsuccessful as we were told that the payroll system continues to default these positions back to the NM cost centre. We would suggest that these positions should be abolished and then re-established with the correct cost centre. This is one way to ensure that the costs for these casual nursing staff are being correctly costed as currently there is close to $1,000,000 YTD that has not been correctly allocated to the clinical areas where these staff are working. In future planning for Activity Based Funding it is important to ensure that the costs are being correctly attributed.
- It was suggested to us that one way to ensure that there is a lower utilisation of overtime, agency and casual staff use is to permanently recruit to a 'nursing pool' to cover backfill for leave. It was estimated that ten additional FTE would be adequate to provide this backfill. Decisions regarding recruiting to productive vs unproductive FTE

should be made as part of the process for establishing the nursing BPF. Recruiting to the level of FTE that will cover planned leave (recreation leave for example) is not unreasonable and provides a solid platform for continuing the compliance with the Rostering Principles. Whether this strategy requires the establishment of a further 10 FTE is questionable as there should be capacity from within the existing established positions to create this nursing pool, if it is deemed desirable. In addition, it would appear that there have been 16 casual nurses employed at some time sitting with the Nursing Management cost centre and it would be important to obtain historical information regarding how and why these positions were established ie/ were they established to provide the leave backfill that it is being proposed to recruit a further 10 nurses to now? Given the current financial situation it would not be responsible to establish additional positions on the basis that it will save money in the longer term as The Park does not have a history of delivering savings.

- In November 2011 a decision was made to engage an external nursing agency in order to supplement the reliance on casual and overtime use. Whilst this may be an important strategy to minimise the Occupational, Health and Safety risks associated with staff fatigue associated with excessive overtime, this is inconsistent with Queensland Health directions to reduce use of agency staff and should be reviewed.
- As is the system in most District's a nursing self-rostering system is used at The Park. This has however resulted in an expectation by staff that their requests will be met regardless of the implications on skill mix and staff continuity. It has also created a competitive culture within the nursing workforce for rostering to what are considered the most desirable shifts due to penalty rates, for example late and weekend shifts. As outlined earlier the increased adherence to the Rostering Business Rules has seen improvements. This was also achieved through extensive consultation with the industrial bodies regarding the parameters of the Rostering Business Rules and shared commitment to them being adhered to.

Industrial and Disciplinary Issues

- In addition to unplanned staff absences due to leave, we were told that at any given time there are a number of staff who are on investigation or disciplinary related alternate duties or leave. It was estimated that over the past year there have been 5-6 staff who fall within this category and are attracting full pay but are having to be backfilled in clinical areas.
- The review team understood that during periods of significant organisational change there are specific industrial consultation processes that should be implemented which assist an organisation in being able to achieve necessary reforms. This includes developing a Business Case for Change which we understand was developed in February 2012. The status of this document is a little unclear, however we understand that the it is currently being costed. We would suggest that further work may be required with this document as the staffing profiles that are being proposed are not 'affordable' and we would suggest are much higher than equivalent services elsewhere in Queensland. Whilst the lack of this document at the beginning of the reform process does not appear to have an adverse impact upon industrial relations, this may be because there has been limited traction with implementing the redevelopment/reform agenda and therefore there has been no need to discuss potentially industrially sensitive issues such as staff

redeployment, staff profile reductions etc. There is also very little commentary regarding non-clinical areas that will also need to consider the impact of the downsizing on the level of need in their areas eg/ management structures, support functions such as maintenance, food services etc. This is a piece of work that needs to be undertaken as soon as possible and should be included in a Business Case for Change (or equivalent document).

3.2 Leadership and Organisational Structure

In reviewing leadership and the structure more broadly there is a sense that The Park is a bit of an 'island'. Whilst it is part of a larger District healthcare organisation it does not appear to be embedded within this structure in a manner that would maximise efficiency, reduce marginalisation, avoid duplication (such as procedure development) and ensure consistency with the District's objectives and expectations. There are potentially a number of factors that impact on this situation some of which relate to historical and cultural factors but there are some more contemporary issues relating to the joining and subsequent separation of the West Moreton and Darling Downs Districts. In July 1 2011 the very large District was split into Darling Downs and West Moreton Districts with The Park remaining in the West Moreton District. However two of the senior positions, those being the Executive Director Mental Health and the Business Manager Mental Health, transferred to the Darling Downs District thereby leaving the equivalent positions in West Moreton District vacant and the longitudinal leadership knowledge of the two incumbents of these positions being lost or at least less accessible. To date these positions remain vacant and a number of the issues we raise within this report would normally fall within the responsibility of these positions. Whilst there is strong and expert leadership in place with the District Executive Director of Nursing and Midwifery assuming the role of A/Executive Director of Mental Health, having stable leadership that provides a single point of accountability and sets the services vision and direction is essential, particularly during a period of significant organisational change.

A number of changes to the organisational structure to support further reform and increase accountability have been suggested to us by management of The Park. Given the current financial position any change to the structure that is not cost neutral would be inappropriate It is also imperative that there is evidence that any changes will assist in meeting The Park's key deliverables as part of the redevelopment and reform agenda. A further factor to consider is to ensure that any new structure does not result in a 'top heavy' structure as The Park downsizes. Below we have outlined two positions that have been suggested to us.

Director of Allied Health- In determining whether this position is necessary, consideration of the broader Mental Health Divisional and District Allied Health structures is required. A single point of leadership for each professional discipline is not an unreasonable objective. There is currently a single point of professional leadership for Medicine and Nursing through The Park Director of Nursing and Clinical Director positions and therefore there is an argument that there should be equity for Allied Health. There is already an HP6 level allied health position that has responsibility for coordinating the Rehabilitation Service and therefore one way of achieving a balanced structure would be through expanding the scope of this role to assume wider responsibility for all Allied Health staff. Whether an HP6 level classification is warranted for a Director of Allied Health (or Assistant Director which may be more consistent with the Divisions and Districts structures) would be for District and corporate HPOC groups to determine, particularly given that the current classifications were based upon individuals and not the organisational structural requirements.

Operations Manager- it could be suggested that the Director of Nursing position currently functions as the Operational Manager and rather than establishing an additional position expanding the scope and responsibility of the Director of Nursing position may be more appropriate. 'Facility based' structures and positions may not be ideal in the current environment of service system continuity being a priority. It is important however to have a structure that invests not only responsibility but also accountability and currently there do appear to be some blurry boundaries between the role of the Clinical Director and Director of Nursing. It would be beneficial to review the position descriptions for these positions with a view to clarifying roles and responsibilities and also to move some operational aspects from the Clinical Director to the Director of Nursing if there is capacity for additional support being provided to the Director of Nursing via the four Nursing Director positions that report to the DON. There already exists a well resourced structure that sits under the Director of Nursing position with four Nursing Director positions, two operational and two in support functions such as education and research. It is difficult to identify how establishing an Operations Manager position as a 'new' and additional unfunded position would be of great assistance at this time. If it was felt that this position was essential one option for achieving the establishment of the position in a cost neutral manner would be to reclassify an existing Nursing Director position, as it is unlikely that the number of Nursing Director positions will be required for the downsized facility. For example, integrating functions of the Nursing Director positions freeing up one to take on more Operational Management responsibility.

Leadership and accountability must be implicit within all management level positions at The Park and a cascading accountability structure with clearly articulated key performance indicators and outcome measures will assist in providing management level staff with the responsibility, authority and accountability to deliver on District expectations. At the present time it is unclear what level of ownership middle management staff have for issues such as the redevelopment and reform agenda, financial management and budget integrity for their areas. This may be as a result of centralised rather than decentralised structures and systems where senior and experienced staff may not always be expected to identify the solutions for their areas of responsibility. There is also a potential that the manner in which some of the activities associated with the redevelopment have been structured does not engage operational management staff to the level necessary. The work of the Redevelopment and Service Development teams appears to be almost disconnected from the operational component of The Park. As we have discussed elsewhere in this report there does not appear to be a sense of urgency with downsizing the service or preparing consumers for transfer to less structured and supervised environments. Whilst it was not made explicit it was our impression that each group believed that this was someone else's role and responsibility. As a consequence it is not happening at a rate consistent with what is required to meet financial and operational goals.
It is important to note that there does not appear to have been a review of the leadership structures that will be required when The Park has downsized and it is timely that this is undertaken. Reporting relationships should also be reviewed as there are some positions, such as the Clinical Director, that have a large number of direct reports some of which appear to have tenuous links. An important principle of any organisational structure is to minimise areas becoming 'silo's' and creating opportunities for further integration. We do not believe any changes should be made to the organisational structure until the Executive Director position has been appointed to as they will need to have the opportunity to make changes consistent with their vision and have ownership of any changes within The Park service.

3.3 Clinical Service Delivery (including MOS, rehab team issues)

Change in practice to reduce the use of seclusion (consistent with Queensland and National mental health plans and expectations) has had a positive impact on the culture of care but has had an unintended consequence of increasing the number of consumers being managed on close observations. This in turn has increased the use of overtime, casuals and agency staff which has significantly impacted on The Park's budget. Whilst the practice change is applauded it is not clear that the risk of a budget blow out was either identified or factored into a business case to ensure that the Division and District were able to make an informed decision and to put in place risk mitigation strategies. Although it is 'after the fact' we believe that a business case should be developed outlining the risks and benefits associated with the practice change and to have this endorsed by the District. This will provide an opportunity for The Park to more formally reflect upon the changes and to develop strategies to minimise the risk of continuing budgetary cost overruns.

The Mental Health Rehabilitation Service is a long established team that we were told was established to ensure that there were practitioners who had responsibility for meeting consumer rehabilitation requirements. We would suggest that having a team that sits outside of and is not accountable to the consumer's treating team assuming responsibility for one of the most important aspects of a consumer's recovery is neither helpful nor contemporary. There are differences of viewpoint regarding how successful the MHRS is on delivering positive consumer outcomes and in enabling consumer recovery. It was reported to us that a number of The Park's consumers who have transitioned to living within Community Care Units (CCUs) have arrived without even basic independent living skills such as banking, cooking, budgeting, house cleaning etc. Whether this is the responsibility of the MHRS, the treating team or the service development team is debatable, but regardless this situation suggests that the reason for the establishment of the MHRS is not being achieved. This service also appears to be 'top heavy' with an HP6 and three HP5 level positions when the entire team currently comprises approximately 27.5 FTE (see Table 1) which is proposed to reduce to 20.5 FTE in the near future. This service currently costs approximately $3m per annum. A strong evidence based argument could be put forward for reform of this team. Ensuring that recovery and rehabilitation is a focus for the clinical treating teams would be enhanced if a proportion of the existing MHRS staff were absorbed within the clinical treating teams. In addition to this being clinically reasonable it would also potentially reduce the need to have duplicated management structures. The number of staff working within the MHRS also seem to disproportionate to the needs of the current and future downsized consumer centred care requirements. The programs provided to us outlining the activities and programs offered by the MHRS appeared to have a very heavy emphasis on diversional activities, which are important but should be balanced with activities that will best equip and support consumers to transition to other residential environments. We would suggest that the rehabilitation and recovery program should have a balance of educational, vocational, therapeutic and recreational (diversion included) activities. We were advised that the MHRS has successfully developed partnership programs with the Non-Government Organisation sector which is an important and contemporary model. Some of the partnership agreements may need to be strengthened to ensure that issues of workcover, liability, access to non-labour resources etc is made explicit and clearly understood by all parties.

It was positive to hear that in response to reports of severely institutionalised behaviours of consumers who transitioned to the new Coorparoo CCU, The Park has initiated a process for review of the ETR/DD MOS. We would support a need to review current models of service delivery and establish of a process to improve rehabilitation services for consumers moving out of The Park. We would suggest that The Park consider a strategy for implementing the endorsed state-wide models of service delivery, including the CCU MOS for ETR/DD consumers and the

Secure Mental Health Rehabilitation Unit (SMHRU)_MOS in the Medium Secure Unit. We were advised that work is underway to finalise the development of the MOS for the Extended Treatment Forensic Unit. This new MOS will provide a unique opportunity to guide the implementation of recovery oriented practices for this new service at The Park. Any reform process would be greatly supported by the development and communication of a clear vision for the direction of service delivery at The Park, which must also be consistent with the already endorsed Statewide Models of Service.

The Park has implemented a structured day program in the High Secure Unit, and is currently establishing the program in the Medium Secure Unit. We were advised that treating teams have observed improvements in consumer satisfaction, reduced consumer isolation, improved staff-consumer relationships and improving staff confidence in the therapeutic skills, as a result of the program. The Park are planning to evaluate the program more formally and it was suggested that they could contact Thomas Embling Hospital (Victoria) who have previously implemented and evaluated the structured day program in a forensic facility.

Table 1- Rehabilitation Team staffing model at The Park

Service Area	HP FTE	Nursing FET	Operational Officer FTE	AO FTE	Total FTE
Service Coordinator	1 x HP6	-	-	-	1 FTE
ATSI	-	-	-	1 x AO5	1 FTE
High Secure	1 x HP5 3 x HP3 0.5 x HP4	2 x CN	1 x OO3	-	7.5 FTE
SMHRU	1 x HP5 1 x HP4 1 x HP3	-	2 x OO3 1 x OO4	-	6 FTE
ETR/DD*	1 x HP5 2 x HP3 1 x HP2	2 x CN	1 x OO4 6 x OO3	-	13 FTE
Totals	**12.5 TE**	**4 FTE**	**11 FTE**	**1 FTE**	**28.5 FTE**

* Planned reduction to 5 FTE for combined ETR/DD service- 1 x HP5, 1 x HP2, 1 x OO4, 2 x OO3, resulting in 20.5 FTE.

3.4 Financial Management

It was initially difficult for us to get a clear picture of the financial position of The Park services. We were provided with a range of data that was generated from internally developed spreadsheets. Whilst these spreadsheets provide a clear account of YTD expenses they do not provide the DSS Panorama operating deficit/surplus information. Whilst we had initially been briefed that The Park budget had a YTD -$3,801,151 deficit which is projected to be a full year $5million dollar deficit (approx), however this is not The Parks actual operating position. In the DSS Panorama information provided to us the operating position is a YTD deficit of -$1,849,358. It would appear that the difference between the 2 figures is related to how revenue associated with consumer fees is treated. YTD revenue of $1,951,753 has been factored into the operating result therefore the over expenditure has been offset by the revenue. Whether this is the way in which the District wants to treat revenue is unclear, but it is currently positively impacting on the bottom line. Whether the financial position of The Park is comprehensively understood by

management is unclear which could be as a consequence of the information they are receiving. A principle should be applied that there must be a 'single source of truth' when it comes to The Parks budget performance and we would suggest that this should be DSS Panorama.
Regardless of the Operating position being somewhat less serious than originally believed, the current expenditure must be reduced as it far exceeds what is budgeted. The revenue from consumer fees should result in an Operating Surplus instead of the current position of it being required to offset the over expenditure.
It is not possible within the scope of this review to provide a detailed financial management plan for The Park, but clearly this is needed for the 2012/13 financial year as there is an expectation that savings made in the current financial year will be used to cover the costs of new services that have been funded by the MHAODD this financial year but not in subsequent financial years. This will be expanded on further in another section of the report.
Although The Park is out of scope for the introduction of Activity Based Funding in the 2012/13 financial year, it is possible that ABF will be the funding source from 2013/14. Currently The Park would be unable to maintain service levels if they are reliant on ABF funding alone as expenditure levels currently exceed what could be reasonably forecast ABF revenue would deliver.
As we have identified elsewhere, the role of Divisional Business Manager has not been filled since the beginning of the financial year. Whilst it is clear that the assistant business managers are very capable their work would be enhanced by having the support of a Business Manager.

Business Case- Establishment Change – we were provided with a copy of **a** Business Case dated 24 February 2012 which outlines the redevelopment of The Park services including what services will close, what new services will be commissioned and the proposed staffing profiles for each unit that is changing. This is an important initiative and we understand will be used as the basis for consultation with the Unions through the District Consultative Forum and will also be used for determining the 2012/13 budget platform. We would however suggest that prior to tabling at the DCF there is further discussion regarding the proposed staffing profiles and whether these are 'affordable' and clinically necessary.

Barrett Adolescent Unit (BAU)- the BAU was identified as one of the areas that was disproportionately contributing to the current deficit. In reviewing their YTD financial performance they are 8% in deficit ($201,000) which is not acceptable from a financial management perspective but is not a significant contributor to the current deficit. There has however been an increase in vacancies identified on this unit since November 2011. We were advised that this was in part associated with staff transferring to other units, including the Kuranda unit which opened in January 2012. The workforce management data that we were provided appears to indicate vacancies of approximately 10 FTE, however The Park management have advised that the number of nursing vacancies is actually 6FTE.
This unit has occupancy rates of 60%, however low occupancy rates are not unusual within Child and Youth units associated with high levels of approved leave, including day and overnight leave, to ensure that community, family, social and educational links are maintained as much as possible. However there should be a process in place that ensures there is an appropriate match between resource allocation and activity. It is not acceptable to maintain 100% staffing for 60% occupancy levels. Although there will be industrial implications in developing a sliding scale of matching occupied beds with staffing levels, this issue should be pursued. If this can be achieved it will allow resources to be freed up for deployment to other areas and as a minimum close observations should be undertaken within existing resources.
It is unlikely that the true cost of the BAU is currently being captured within the Adolescent cost centre as the Nursing Management cost centre with 16 causal FTE as well as the High Acuity cost

centre which is 22 FTE over budget may be hiding some of the actual expenditure in not only the BAU but all of the consumer areas, thereby creating an artificially lower expenditure base.
We were advised that in 2007 staffing profiles were increased in response to 'high acuity'. These higher staffing levels have been maintained since this time and now appear to have been embedded within the regular staffing profile, regardless of occupancy or acuity. Again we would suggest that this situation needs to be reviewed to ensure that 'acuity' is assessed on a case by case basis and at regular intervals in a consumers care.

High Acuity- The 'High Acuity' cost centre has a significant over expenditure equivalent to 22 FTE (approximately $1.9 million). It has been difficult for us to completely understand how 'high acuity' functions as there does not appear to be a clearly articulated criteria and documented process in place to administer and manage the allocation of additional staff for 'high acuity' purposes. The Park management had identified that this cost centre was posing particular budgetary and workforce management issues and had independently decided to form a working group to develop a procedure for 'High Acuity'. During our visit to The Park the working group met and as a consequence decided that rather than developing a procedure, the use of 'high acuity' would be ceased. Whilst this appears to be a responsible decision, it will not be straight forward to implement. There are some areas (as outlined under the Barrett Unit) that have 'high acuity' resources embedded within their staffing profile and this has been the case for several years. We would suggest that careful consideration of how staff and the industrial bodies will be engaged and consulted in relation to the cessation of 'high acuity' be undertaken, as it is likely that there will be strong resistance to this occurring. An interim procedure for 'high acuity' should therefore be developed to ensure that until the practice can be ceased there is an accountable and transparent process and criteria applied.

Consumer Revenue- Currently there are 143 consumers who are eligible to pay accommodation fees. Of these 66 pay the full fee, 10 have a partial waiver, 16 have a full waiver, 8 pay specifically negotiated amounts and 43 make no payment. Assuming the consumers who have received waivers are eligible for the waiver this leaves 43 consumers who are not making payments towards their accommodation. If they are required to pay the full amount the potential revenue currently lost is $23,392 per fortnight. Over a full financial year this equates to $608,192. In the financial reports we received there is a line item titles 'asset writedown'. We were told that this is the amount of funding that is written off due to non-payment of consumer fees, though this a little confusing as there are amounts allocated to 'asset writedowns' in cost centres that we would not have thought there should be consumer fees, such as 'High Acuity' and the Adolescent cost centres. This is a significant amount of revenue that is not being recouped, and given that The Park has no capacity to obtain other forms of own source revenue (such as private health insurance, DVA etc) this should be actively pursued. We were told that there have been attempts made in the past to address the problem of consumers refusing to pay fees, it is unclear what the final outcome of this activity was. A District Recruitment Officer was engaged to develop a strategy but this does not appear to have occurred.
The issue of consumer fees is not just a financial matter. Currently those consumers at The Park who are unwilling to pay fees have their full pension or other benefit as 'disposable' income. In the absence of these consumers needing to manage their personal budget to accommodate costs that they will be exposed to when they leave The Park, there is a potential for these consumers to have difficulty in maintaining an affordable lifestyle in the community. This can lead to a number of problems including the risk of homelessness. If it is not possible to ensure that these consumers are paying fees an alternate 'artificial' budget process should be developed with these consumers to ensure that they have a clear understanding of the costs associated with living outside of The Park.

Other financial matters- Overall expenditure has been on an upward trajectory since October 2011 with a secondary significant peak from January 2012. It appears that the March result is indicating that expenditure is not rising further and has plateaued but this is still maintaining expenditure far in excess of what is budgeted and approved.
Overall there is an FTE variance of -23.18 (when unproductive FTE is removed) with the bulk sitting in nursing and operational areas. Whilst the number of 'special's' associated with the 2 consumers discussed elsewhere in the report contribute some of this FTE variance it does not explain the full budget over expenditure.

Nursing overtime is currently 11,000 hours (approx 70%) higher than the previous financial year and Operational stream overtime is 1,400 hours higher (300%).
At the same time nursing casual hours are the lowest they have been in comparison to the past five financial years. Agency nursing utilisation has increased however, with virtually no agency use in 2010/11 in comparison to 2,200 hours YTD. Whilst the introduction of external staff through a nursing agency has been implemented to reduce staff fatigue associated with excessive overtime, this decision is inconsistent with Queensland Health expectations that use of agency staff will be reduced or ceased. As soon as possible the use of agency staff should be ceased.
Sick leave have been declining since October 2011 and sick leave rates are currently less than the two previous financial years. Therefore sick leave backfill does not explain the higher nursing input costs.
Although occupied bed days have fallen by approximately 30% there has been no corresponding fall in costs. As outlined under the Barrett Adolescent Unit it is important to ensure that there is a match between resources and activity. Maintaining 100% staffing with diminishing occupancy is not affordable or an appropriate use of public funds. Whilst the bed numbers have been reduced for the Dual Diagnosis beds that have closed for occupancy purposes, there has been no reduction in costs associated with the bed closures. Therefore the cost of 9 beds is currently the equivalent to managing the initial 40 beds. In the absence of formal reallocation of resources associated with the bed closures, the DD unit should continue to be recognised as a 40 bed unit with the occupancy reflecting this number of beds ie/ 25% occupancy. This will also provide an opportunity to include the DD unit in the strategy to reduce resources in line with activity.

Leave management- Currently there are 66 staff members (25% of current workforce) who have leave in excess of the approved accrual level. The over approved accrual ranges from 2.6 hours to 302 hours. ADO balances vary with the maximum number of ADO hours accrued being 279 hours, however the bulk of staff appear to have several days as a minimum accrued. Whilst we understand that staffing pressures may have resulted in delaying active management of leave and ADO accrual, this situation needs to be addressed as soon as possible.

On-site tenants- Currently The Park 'hosts' a number of Statewide services, such as QCMHL and QCMHR. It was suggested to us that these services impact on the budget of The Park and an example was given to us that recently the QCMHR upgraded a number of their positions resulting in higher classifications and therefore costs. Although Divisional management had to sign off on these upgrades management of the Park were not consulted although it is their budget that must accommodate the additional expense. We understand the QCMHR will be transferring to Metro South Health Service District in the near future and when this occurs The Park must ensure that the funding allocation that is transferred is only the approved funding that they have been allocated. In the absence of The Park having an unfunded liability associated with the upgraded positions it is not reasonable for them to also have to transfer the additional funds to another District. The West Moreton Mental Health Division may need to negotiate the

terms of the transfer to ensure that The Park's budget does not continue to be adversely impacted.

Medical Budget- It was suggested that a cost driver could be as a result of over reliance upon VMO medical staff, particularly in the Prison Mental Health, however there is no evidence that this is the case. Currently 1.0FTE of VMO is approved for the Prison Mental Health service however the service has recruited and is using slightly less than the approved FTE. In providing services to prisons that are spread across a range of geographical locations it is not unusual or inappropriate to utilise locally based medical practitioners who are then paid VMO rates. Currently there are 3 GP's employed on this basis to provide mental health services to prisons.
VMO sessions in other areas are also relatively conservative and do not appear to be inappropriately high and in fact the number of VMO FTE have progressively fallen over the past four financial years.

3.5 Management of change associated with The Park redevelopment

Reform under the QPMH
The overall impact of downsizing under the first stage of the QPMH was to reduce beds from 192 beds in 2006/07 to 152 beds by 2012 (Stage 1) and change the profile of consumers to a forensic/secure service environment. These changes, as well as future proposed changes, are demonstrated in the table below.

Table 1: planned bed changes at the Park under the Queensland Plan for Mental Health 2007-17 (QPMH)

Bed type	Prior to the QPMH (2006)	QPMH Stage 1 bed additions/ reductions	Current beds (Feb 2012)	Bed no. post Stage 1	Stage 2 bed additions/ reductions^	QPMH bed target for The Park^
ETR and DD	82	-54	51*	28	-28	0
High secure	61	9	70	70	15	85
SMHRU	34	Nil	34	34	-9	25
Forensic ETR	0	20	0	20	20	40
Adolescent rehab	15	-15	15	0	0	0
Total beds	**192**	**-40**	**170**	**152**	**-2**	**150**

*45 of these 51 beds were occupied at February 2012
^ These proposed Stage 2 QPMH bed changes are not yet funded.

Delays in the construction of the four new Community Care Units (CCUs) and the relocated adolescent rehabilitation unit have impacted on the reform process at The Park, by disrupting original planning for transfer of consumers and relocation of staff. One of the new CCUs (at Coorparoo) commenced operation in September 2011, allowing nine consumers to transfer from The Park. Two more CCUs (at Logan and Bayside) are due to be operational by early 2013, and the final CCU (at Gailes) is due to operate from early 2014. The relocation of the BAU to Redlands has experienced significant delays due to environmental planning issues, and it is estimated that it will be operational in mid 2014. As mentioned previously, it was suggested to the review team that current planning was being undertaken with an assumption that relocation of the adolescent unit may not proceed. This approach is not supported by the MHAODD- in spite of delays, the retention of an adolescent rehabilitation unit on The Park campus, which will provide predominantly forensic services to adults is considered inappropriate.

Financial impacts of Stage 1 of the QPMH
Under the QPMH it was agreed that 66% of costs for new services including Logan CCU, Coorparoo CCU, Gailes CCU and Redlands Adolescent Unit would be met by The Park. It was initially estimated that $9.2 million would be transferred out of the Park. The latest plans by the MHAODD indicated that a total of $9.072 million will need to transfer to new services by

2014. The transfer amounts for two of the new units- Redlands Adolescent Unit and the Gailes CCU remain unconfirmed between the MHAODD and West Moreton HSD. It is recommended that The Park, Metro South HSD and the MHAODD work together to enable confirmation of all funding transfers in and out of The Park over the next two years as a matter of priority.

Coordination of redevelopment/reform project

Significant financial support ($4,007,159) has been provided by the MHAODD to support redevelopment and reform at The Park since 2008-09:

2008/09: $245,000 to support implementation of capital works projects and change planning

2009/10: $660,000 for pre-commissioning/ change management activities

2010/11: $900,000 for pre-commissioning/ change management activities

$1,000,000 non-recurrent for operational costs due to delays in operation of new beds

2011/12: $750,000 for pre-commissioning/ change management activities

$452,159 non-recurrent for operational costs, due to delays in consumers transfers

The pre-commissioning funding was provided with agreement that The Park would coordinate all activities related to community consultation, management of staff relocation, management of consumer relocations, implementation of service models, recruitment strategies and commissioning activities. Pre-commissioning funding has been used to fund the Redevelopment Team who we were advised work separately to the service development area of The Park. We would suggest that a greater level of integration and alignment between planning for structural and organisational downsizing and the reform of clinical service delivery is required to ensure that the vision for change at The Park is achieved. Significant longer term gains could be made by integrating these two related areas of work, under a one plan for downsizing and clinical reform, with a clear vision and goals, and a single point of accountability.

The MHAODD has indicated to The Park in previous years, that non-recurrent funding may be available to support HR implications of the downsizing including provision of HR support, relocation funding and funding for VSPs and or VERs. To date, there has been no request from The Park to use this funding. The MHAODD have advised that while it has been possible to identify some non-recurrent funding for this purpose to date, this may not be available within existing budgets in future years. It is suggested that The Park could consult with the MHAODD regarding possible uses and amounts of additional funding to support downsizing from 2012-13.

Progress in downsizing

Since 2006/07 there have been 30 bed closures at The Park, in the ETR and DD areas. Currently it is reported that of 51 beds still open, 45 are occupied, and new admissions are not being accepted. It was unclear what changes had been made to staffing over the past 5 years, related to bed closures. It was also not clear what financial savings have been achieved in terms of reduced staffing costs and reduced consumer costs. Barriers to not ramping down services were described to us as delays in commissioning dates for new units (e.g. leading to inability to transfer staff to new services); industrial relations issues (including the promise of no forced job losses); delays in establishing an agreed interim ETR- DD staffing profile and cultural issues (e.g. staff resisting change to service models). Planning for redevelopment has been complicated by changes in delivery dates for capital projects, which have occurred due to a broad range of unexpected issues. Ongoing unanticipated delays are likely to be unavoidable, requiring ongoing flexibility and close liaison between The Park and the MHAODD.

As outlined earlier a business case for staffing changes was developed in February 2012, which indicates that planning for changes to staffing is occurring, however this did not include financial data, and did not consider the impact of the new Gailes CCU. The business plan

indicated that overall there will be a decrease of 2.38 FTE non-clinical positions and 14.28 FTE clinical positions by 2014. We were advised that the staffing profile for the interim 28 bed ETR-DD service has not yet been clearly defined in terms of staffing profile and model of service. The proposed staffing profile, provided in the draft business case, appeared over-resourced in comparison to like services. It is unclear at this stage how planned staffing changes will result in meeting the need for transfer of funding to new services, although we were advised that a costing exercise was in progress.

It was suggested to us that not all consumers at The Park who require clinical residential care will be considered suitable for transfer to a CCU environment, particularly those with dual diagnoses of intellectual disability. While, the unique needs of consumers who have experienced long term institutional mental health care are recognised, it is important to note that there is a longer term plan to close all ETR and DD beds at The Park. The discharge planning for all consumers needing ongoing clinical residential care needs to consider working towards a CCU transfer. The four new CCUs being developed under the QPMH were funded with the primary purpose of deinstitutionalisation and closure of ETR and DD services at The Park.

Our overall impression of the downsizing process was that while a significant amount of important work is being undertaken to meet the needs of the redevelopment project, there appeared to be a lack of sense of urgency about the need to manage change, particularly from a workforce and financial perspective. We felt that in general, this may be caused by delays in capital works projects resulting in a more prolonged change process than originally anticipated, staffing changes and not having a single, coordinated point of leadership for the full range of reforms needed to achieve the goals of the redevelopment. It is suggested that an overarching change management plan which provides a vision for The Park and outlines strategies and timeframes for clinical reform (including changes to service models), workforce and industrial management, opening of new services and bed closure management should be developed, with oversight from the district and The Park executive. The plan could identify agreed roles of key internal and external stakeholders including those in West Moreton HSD, Metro South HSD and the MHAODD. Planning should allow for the flexibility needed to adapt processes to unavoidable changes, such as delays in capital works projects. The appointment of appropriate persons to key leadership positions, including the roles of Business Manager and Executive Director, are essential for the progression of this work. It is also suggested that a communication and planning mechanism with appropriate levels of representation from The Park, Metro South and the MHAODD could be implemented to ensure the aims of the QPMH, for both The Park and new services being developed in Metro South HSD are realised.

Recommendations

1) Review the nursing skill mix and profile for each inpatient unit and identify opportunities to replace Registered Nursing positions with Enrolled Nurse and Enrolled Nurse Advanced Practice positions.
2) Following completion of recommendation 1 establish the Nursing BPF for The Park ensuring unfunded and not approved positions are not embedded within the BPF profile.
3) Place a hold on further establishment and recruitment to nursing positions until it is clear that deployment of surplus to requirements staff have been appropriately deployed to existing vacancies.
4) The role and function of the Mental Health Rehabilitation Service be reviewed at the first available opportunity with a goal of more effective integration with clinical teams and to identify cost savings.

5) Review and/or establish partnership agreements with relevant Non-Government Organisations to provide clarity regarding issues such as liability and access to District resources.
6) Expedite the recruitment to the key Divisional positions of; Executive Director Mental Health and Business Manager Mental Health.
7) As a matter of priority review the February 2012 Business Case for Change to ensure that the proposed staffing profiles are affordable and consistent with operational and clinical requirements.
8) Develop a 'sliding scale' of resource allocation to match staffing levels with occupancy and thereby activity for all inpatient units, particularly the Barrett Adolescent Unit.
9) In the absence of 'High Acuity' being ceased, develop and document a procedure that clearly articulates the criteria, authorisation and process for it's use.
10) Explore options for ensuring revenue associated with consumer fees is realised.
11) WMHSD, the MHAODD and MSHSD work together to reach agreement on funding transfer amounts related for service relocations and to coordinate other important aspects of the redevelopment process including workforce related issues.

EXHIBIT 260

4 FINDING AND RECOMMENDATIONS- Consumer Management Issues*

[redacted]

It is clear that this level of staff supervision is not required for clinical reasons within a high secure mental health environment that relies on three pillars of security; environmental/physical, procedural and most importantly relational. It is unclear what additional benefit would be derived from having so many staff observing [redacted]

In discussion with Dr Neallie, as the Clinical Director and an expert in the provision of Forensic Psychiatry, he believes that the current level of observation is unnecessary and in his opinion what would be clinically appropriate would be;

- Whilst [redacted] is confined in [redacted] bedroom, one Registered Nurse undertaking constant visual observations.
- When [redacted] is in other areas of the consumer unit or facility three staff comprising 1x Registered Nurse and 2x Security Officers.

Whilst it is not unreasonable for Corrective Services to express an opinion on the management of [redacted] it is not reasonable for costs associated with additional

security measures that have been required by Corrective Services to be borne by The Park. It is estimated that the cost of the additional security requirements has adversely impacted on The Park's budget to the amount of $269,523 YTD which is projected to be $652,116 by the end of the financial year. To minimise the risk of The Park staff beginning to identify that the current staffing arrangements are necessary to manage this consumer safely, that clinical and operational management of the Park make it very clear what they believe is the appropriate staffing to meet the individuals clinical needs and the maintain a safe environment. If this is not successfully undertaken any future reduction in staffing supervision (if accepted by QCS) is likely to be strongly opposed by staff and could result in industrial action, which to date has been avoided in managing this consumer.

It is therefore recommended that Queensland Health negotiate with Queensland Corrective Services to have this amount transferred to The Park budget to off-set the adverse impact this has had on their budget performance. If this is not possible Queensland Health should consider providing an equivalent amount as 'debt forgiveness' for The Park's end of year budget outcome.

Alternate placement at the purpose designed and constructed Prison ward at the Princess Alexander Hospital, with additional mental health input, should also be considered as we understand that this arrangement has been successful in the past and would be a more cost effective placement option than the current arrangement.

To ensure this situation does not occur into the future Queensland Health and Queensland Corrective Services should develop a Memorandum of Understanding that clearly establishes the parameters for an inter-departmental transfer of budget when and if a similar situation arises in the future.

Recommendations

12) Obtain a further second opinion for diagnostic and placement purposes.

13) Re-negotiate staff supervision requirements with Queensland Correctional Services.

14) Develop and inter-departmental agreement between Queensland Health and Queensland Correctional Services that can assist The Park in recouping additional costs associated with the management of In the absence of a transfer of funds being viable 'debt forgiveness' to the equivalent of the additional cost should be made available to The Park.

15) Review the possibility of transferring to the more secure Prison Ward at Princess Alexander Hospital.

EXHIBIT 260

Recommendations

16)
17)

***- Note: Consumers were not interviewed nor were their medical records reviewed. The opinions expressed are in response to information provided by the treating service and team.**